PRIOR AUTHORIZATION for (INTRACEPT PROCEDURE) INTRA-OSSEOUS BASIVERTEBRAL NERVE ABLATION

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Member & Provider Services at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Date Requested:	Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Section II: PROVIDER(S) INFORMATION

***Rendering* Provider:**			***Rendering* Provider Address:**		
Provider NPI #:	**Provider TIN #:**	**Contact Person:**	**Phone:** ( )	**Facsimile:** ( )	**Email Address:**
***Facility/Hospital*:**			***Facility/Hospital* Address:**		
Facility NPI #:	**Facility TIN #:**	**Contact Person:**	**Phone:** ( )	**Facsimile:** ( )	**Email Address:**

Section III: PRE-AUTHORIZATION REQUEST

A. Nature of Request: ***Please check.***
☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth ☐ Urgent

B. Requested Date(s) of Service:
From: **To:**

C. Place of Service: ***Please check.***
☐ Ambulatory Surgical Center ☐ Inpatient ☐ Office ☐ Outpatient

D. Primary Diagnosis/ICD-10 Code:

E. Secondary Diagnosis/ICD-10 Code:

F. Are services related to a motor vehicle accident? ☐ Yes ☐ No
Date of Accident: _____

G. Are services related to a work-related injury? ☐ Yes ☐ No
Date of Work Injury: _____

H. Service (s) Requested: ***Please list all requested services regardless of pre-authorization requirement. Unlisted codes cannot be pre-authorized.***

Service: _____ CPT/HCPCS code: _____ ☐ Bilateral ☐ Left ☐ Right ☐ Repeat

Service: _____ CPT/HCPCS code: _____ ☐ Bilateral ☐ Left ☐ Right ☐ Repeat

Service: _____ CPT/HCPCS code: _____ ☐ Bilateral ☐ Left ☐ Right ☐ Repeat

I. QUESTION	YES	NO	COMMENTS/NOTES
1. Is the patient 17 years of age or older and is skeletally mature?	☐	☐	
2. Has the patient experienced chronic low back pain for at least 6 months?	☐	☐	
3. Did the patient's low back pain fail to improve after a trial of NSAIDS or Acetaminophen for at least 6 months?	☐	☐	
4. Did the patient's low back pain fail to improve after a trial of activity modification for at least 6 weeks?	☐	☐	
5. Did the patient's low back pain fail to improve after a trial of physical therapy with a minimum of 4 visits over 8 weeks?	☐	☐	
6. Is there documentation that states the MRI showed Type I or II Modic changes of the L3-S1 vertebral level endplates?	☐	☐	***Please submit MRI report.***
7. Does the patient have a minimum ODI (Oswestery Low Back Disability Questionnaire) score of 30 (100-point scale)?	☐	☐	***Please submit report.***
8. Does the patient rate their pain at a minimum of 4cm on the 10cm VAS (Visual Analog Scale)?	☐	☐	
9. Will Intra-Osseous Basivertebral Nerve Ablation be performed by a board-certified physician who is also trained in Intracept procedure and is PEHP approved for the Intracept procedure?	☐	☐	
10. Does the patient have a history of osteoporosis?	☐	☐	
11. Does the patient have a Beck Depression Inventory (BDI) score > 24 (moderate, severe, or extreme depression)?	☐	☐	***Please submit report.***
12. Does the patient exhibit 3 or more of the following Waddell's signs of organic behavior?	☐	☐	
12.a. If "*Yes*", which signs were positive? ***Please check all that apply.*** ☐ Acetabular rotation (pain elicited in the first 30 degrees of rotation) ☐ Axial loading (lumbar pain elicited when pressing downwards vertically on the patient's head) ☐ Distracted straight leg raise discrepancy ☐ Non-anatomic tenderness ☐ Overreaction ☐ Regional sensory disturbance ☐ Regional weakness ☐ Superficial tenderness	☐	☐	
13. Does the patient have spondylolisthesis at or above the segment intended to be accessed during BVNA?	☐	☐	
14. Does the patient have lumbar regional central canal stenosis with neurogenic claudication?	☐	☐	
15. Does the patient have anatomy, hardware, or other obstructions that would negatively affect access to perform BVNA?	☐	☐	

Additional Comments:

By submitting this form, I attest that the information provided is true and accurate to the best of my knowledge.

Please fax completed form and medical records to 801-366-7449.